REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

REVIEW OF THE DEPARTMENT OF HEALTH SERVICES' X-RAY REQUIREMENTS FOR THE DENTI-CAL PROGRAM

P-433

JUNE 1984

REPORT BY THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

P-433

REVIEW OF THE DEPARTMENT OF HEALTH SERVICES' X-RAY REQUIREMENTS FOR THE DENTI-CAL PROGRAM

JUNE 1984

Telephone:
(916) 445-0255

Thomas W. Hayes
Auditor General

STATE OF CALIFORNIA
Office of the Auditor General
660 J STREET, SUITE 300
SACRAMENTO, CALIFORNIA 95814

June 11, 1984

P-433

Honorable Art Agnos, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 3151
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report which indicates that in 1982 the Department of Health Services implemented additional administrative controls to insure that the California Dental Service pays only those claims for services under the program that are properly documented. Between 1981 and 1983, the percent of dental procedures which the CDS denied for payment increased from 3.8 percent of the total procedures billed in 1981 to 8.3 percent in 1983.

Respectfully submitted,

for THOMAS W. HAYES
Auditor General

TABLE OF CONTENTS

SUMMARY

The Department of Health Services (department) has implemented controls to improve its administration of the Denti-Cal program. Subsequent to the implementation of these controls, the rate at which the California Dental Service (CDS) paid claims erroneously declined considerably. In the last quarter of 1982, department auditors determined that 9.7 percent of the payments approved by the CDS were erroneous. One year later, the CDS had reduced this error rate to 4.4 percent. Moreover, the percent of dental procedures for which the CDS denied payment increased to 8.3 percent of the total procedures billed in 1983, up from 3.8 percent in 1981. Our review of a sample of dental procedures for which the CDS denied payment in 1983 found that the CDS denied payment for 42 percent of those procedures for reasons that relate to X-ray documentation.

Dental care providers we interviewed said that the documentation requirements of the Denti-Cal program, particularly the requirements for X-rays, are excessive. The department maintains that its requirements for X-rays are equivalent to standards emphasized in dental schools and in the California Dental Association handbook Quality Evaluation for Dental Care. In April 1984, the department notified the CDS in writing of its relaxed X-ray requirements for restorations, and in May 1984, the department informed the CDS of its modified X-ray requirements for extractions.

During fiscal year 1982-83, the department paid $144.9 million to the CDS for Denti-Cal services. Of this total, $134.3 million represented payments to providers. The remaining $10.6 million represented reimbursements to the CDS for the administrative costs associated with processing claims. The federal government reimbursed the State $75.1 million for the program.

This report also responds to the Legislature's request for information on changes in the number of Denti-Cal providers in recent years and on the number of X-rays required to justify payment for dental procedures funded by Denti-Cal.

INTRODUCTION

In November 1965, the Legislature created the California Medical Assistance Program, commonly known as "Medi-Cal." This program, authorized by Title XIX of the Social Security Act and Section 14000 et seq. of the California Welfare and Institutions Code, pays for a variety of health care services provided to beneficiaries. In addition to providing physician, pharmacy, and hospital services, Medi-Cal also funds dental services for beneficiaries. Medi-Cal recipients can receive dental services from the provider of their choice as long as the provider elects to participate in the Medi-Cal dental program, or "Denti-Cal." The state and the federal government jointly fund Medi-Cal and Denti-Cal.

The Department of Health Services (department) is the state agency responsible for administering the Denti-Cal program. The department contracts with the California Dental Service (CDS) to process and pay claims for covered dental services on an "at-risk" basis. Under the at-risk contract, the CDS receives advance premiums from the department to pay for dental services provided to Medi-Cal beneficiaries. The premiums are based on the number of persons eligible for the Denti-Cal program. If service costs are greater than the amount received through premiums, the CDS assumes liability, or risk, for the losses. If service costs are less than the amount received through premiums, the CDS retains any excess up to 5 percent of the total payments made by the State and remits the remainder to the State. Dental services are

provided by any individual, partnership, clinic, group, association, corporation, or institution that meets applicable state standards for participation in the Denti-Cal program.

During fiscal year 1982-83, the department paid $144.9 million to the CDS for Denti-Cal services. Of this total, $134.3 million represented payments to providers. The remaining $10.6 million represented reimbursements to the CDS for the administrative costs associated with processing claims. The federal government reimbursed the State $75.1 million for the program.

The Denti-Cal program is to be administered in accordance with federal and state requirements. The department, in cooperation with the CDS, has compiled the guidelines that apply to Denti-Cal in a manual entitled Criteria for Dental Services Under the Medi-Cal Program (criteria manual). The criteria manual, which is distributed to providers who participate in Denti-Cal, provides guidelines for the services covered by Denti-Cal and for the documentation that the department and the CDS require providers to submit with their claims. For example, to receive payment for restoring a tooth, the provider must submit dental X-rays justifying the need for the restoration or an explanation of why the service was necessary and a statement of why X-rays were not included with the claim. The criteria manual requires that diagnostic X-rays fully and clearly show the appropriate teeth and surrounding areas that are relevant to the beneficiary's symptoms. The criteria manual also identifies the specifications for diagnostic X-rays.

Of the 162 dental procedures covered by the Denti-Cal program, 95 procedures require that X-rays accompany the claim. According to CDS records, approximately 70 percent of the claims paid by the CDS between 1981 and 1983 were accompanied by X-rays.

The CDS is responsible for paying or denying payment for dental services in accordance with the provisions of the criteria manual. Providers submit a claim describing the dental services (procedures) provided to a single beneficiary; claims commonly list several procedures, that may include, for example, an initial examination, X-rays, and the necessary dental treatment.

To ensure that the CDS properly pays or denies dental procedures, a CDS auditor or dental consultant reviews all claims. The auditor, who is usually a trained dental assistant or hygienist, ensures that each dental procedure listed on a claim is covered by Denti-Cal and is sufficiently documented. An auditor may decide to deny a procedure on grounds that the procedure is not covered by the program or is not accompanied by required X-rays. On the other hand, decisions that pertain to the acceptability of procedures, and require professional judgment and interpretation, are made only by a CDS dental consultant who is a licensed dentist.

The dental consultant reviews questionable claims and any supporting documentation such as X-rays or a written explanation from the provider about the dental services provided. The dental consultant may

deny payment for the procedure on grounds that the procedure does not conform to standard dental practice. For example, a consultant may determine that restoring a badly decayed tooth was not reasonable because the X-ray shows that the tooth was in such bad condition that a restoration would not save the tooth. In this case, the consultant may deny payment for the restoration on the grounds that standard dental practice requires that the tooth be extracted rather than restored.

SCOPE AND METHODOLOGY

This analysis responds to specific questions by the Legislature regarding the criteria used by the Department of Health Services and by the California Dental Service to determine the quality and quantity of X-rays required to justify payment of a Denti-Cal claim, the number and types of Denti-Cal services for which payment has been denied by the CDS, and the reasons for the denials. The Legislature also asked us to determine if there has been a change in the number of providers in the Denti-Cal program since 1980.

In performing this analysis, we examined the Denti-Cal contract, Denti-Cal regulations and legislation, the Criteria for Dental Services Under the Medi-Cal Program furnished to providers, and the California Dental Association handbook Quality Evaluation for Dental Care. We also interviewed personnel at the department, the CDS, the American Dental Association, and the California Dental Association, and spoke with five providers who participate in the Denti-Cal program. In

addition, we reviewed a sample of Denti-Cal claims and reviewed reports that the CDS provides to the department. Finally, we reviewed the department's audit reports covering the CDS' processing of claims. To determine the number and types of Denti-Cal procedures for which the CDS denied payment, we used data provided to us by the CDS and the department.

In the following sections, we discuss the department's actions to control the costs of the Denti-Cal program, the increase in CDS denials of payment for dental procedures, and the concerns of some members of the dental community that documentation requirements of the Denti-Cal program are excessive. We also respond to the Legislature's questions regarding changes in the number of Denti-Cal providers and the number of X-rays required to justify payment for claims.

We did not attempt to determine if the department's criteria for X-rays are, in fact, excessive. Such a determination requires the professional judgment of a dentist. Moreover, as our report indicates, even professionals in dental care do not agree on the criteria for X-rays. We therefore limit our report to presenting the views of the department and some members of the dental community on this matter.

ANALYSIS

The Department of Health Services (department) has recently implemented procedures to verify that the California Dental Service (CDS) pays Denti-Cal providers only for necessary dental services covered by the Denti-Cal program. Subsequently, the rate at which the CDS erroneously paid for services declined from 9.7 percent in the last quarter of 1982 to 4.4 percent in the last quater of 1983. The department is strictly interpreting the criteria to ensure that the CDS pays only for services that are covered by the program and that are properly documented. Consequently, the number of procedures for which the CDS denied payment increased from 3.8 percent of total procedures billed in 1981 to 8.3 percent in 1983. We reviewed claims for dental procedures for which the CDS denied payment in 1983 and found that 42 percent of the procedures we reviewed were denied for reasons that relate to required X-ray documentation. The providers we interviewed told us that the documentation requirements of the Denti-Cal program, particularly the requirements for X-rays, are excessive. However, department officials stated that the documentation requirements currently in effect require only X-rays that providers should normally take for examinations and treatment.

The Department of Health Services Has Acted To Control the Costs of the Denti-Cal Program

The department conducted a comprehensive audit covering the CDS' administration of the Denti-Cal program for the period January 1980 through November 1981. The audit found that the CDS had paid for inappropriate or unnecessary dental services during those years. As a result, the department made several recommendations designed to improve CDS performance in complying with requirements for evaluating and authorizing payments to providers.

The department has also implemented procedures to verify that the CDS pays Denti-Cal providers only for necessary dental services covered by the Denti-Cal program. The department, in cooperation with the CDS, revised the Criteria for Dental Services Under the Medi-Cal Program (criteria manual) that the CDS issued to the providers and began monitoring the Denti-Cal claims processed by the CDS.

In January 1982, the CDS sent to Denti-Cal providers the revised criteria manual in which are listed all dental services covered by Denti-Cal, including specific limitations for certain services. The manual identifies the documentation that providers must submit with their claims for payment. (An excerpt from the criteria manual pertaining to general X-ray policies is presented in Appendix A.) In the letter transmitting the criteria manual to providers, the CDS emphasized that it might not be able to pay a claim for which the provider did not fully

document the need for the service. In particular, the CDS stressed that providers must submit X-rays and/or narrative documentation with their claims.

In July 1982, the department formed a Denti-Cal monitoring unit. One of the duties of this unit is to conduct monthly audits of Denti-Cal claims at the CDS. The purpose of these reviews is to verify that the CDS complies with the requirements of the criteria manual in determining that only reasonable and necessary services covered by the program are paid and that services are properly documented.

The dental consultant in the department's monitoring unit provided the following description of the unit's monitoring activities. Each month, the monitoring unit, consisting of one dentist and two dental hygienists, compare at least 1,000 claims with the requirements of the criteria manual. The dentist and dental hygienists review each claim to determine if (1) the CDS paid only for services covered under the criteria manual; (2) the services were reasonable and necessary; (3) the CDS paid the correct amount for the services; (4) the beneficiary was eligible for the services; and (5) the provider had obtained prior authorizations when required. In performing its monthly reviews, the department strictly interprets the provisions of the criteria manual.

The department representatives and the CDS then hold a conference in which the department's monitoring unit summarizes the claims that were reviewed and discusses any questionable payments with

the CDS. At this point, the CDS has the opportunity to refute any department finding that claims were improperly paid. In some instances, the CDS can provide additional information to the department that shows that the CDS did pay the disputed claims properly; the department does not include these claims in establishing an error rate for amounts overpaid to providers during the month. In other instances, the department and the CDS never reach agreement on whether the disputed claims were paid properly. Even though the CDS continues to dispute these claims, the department includes the disputed claims in establishing an error rate. The error rate is reported as a percent of the total payments made by the CDS.

The manager of the department's CDS contract monitoring unit told us that based on the monthly error rate, the department determines the amount the CDS overpaid providers during the year. The department reduces the estimated program cost for the upcoming year to reflect overpayments projected from these audits.

We compared the CDS error rates established by the department for October through December 1982 with the error rates for the same period during 1983. Table 1 presents a comparison of the rates of erroneous payments made by the CDS for dental services.

TABLE 1

COMPARISON OF RATES OF ERRONEOUS PAYMENTS MADE BY THE CDS FOR DENTAL SERVICES OCTOBER THROUGH DECEMBER 1982 AND OCTOBER THROUGH DECEMBER 1983

	Error Rate (Percent of Total Payments)	
Month	1982	1983
October	10.1	4.9
November	11.3	5.4
December	7.6	2.9
Three month average	9.7	4.4

Source: Department of Health Services; we did not audit these figures.

The table demonstrates a considerable decline in the CDS error rate from 1982 to 1983. For example, the department projected that 7.6 percent of the payments that the CDS approved in December 1982 were improper. However, one year later, the department projected that only 2.9 percent of the CDS payments were in error.

According to the CDS, when the department first performed monthly audits at the CDS in September 1982, the department expected the CDS to pay claims in strict accordance with all provisions of the criteria manual. CDS officials told us that this reflected a change in the way the department had previously interpreted the criteria manual. As the reduced error rate suggests, it appears that the CDS is adapting to the department's stricter interpretation of the criteria manual.

The Rate at Which CDS Is Denying Payment for Denti-Cal Procedures Has Increased

To determine if the stricter controls were followed by an increase in the number of CDS denials of billed procedures, we compared data on procedures denied by the CDS during the three-year period, January 1981 through December 1983; during these three years, the percent of procedures denied for payment by the CDS more than doubled. In 1981, the CDS denied payment for 3.8 percent of the total procedures billed by providers. In 1983, the percent of procedures for which the CDS denied payment increased to 8.3 percent. Table 2 shows the number and percent of procedures paid and denied from 1981 through 1983.*

*The CDS records procedures denied according to the date the claim was processed; it records procedures paid according to the date of service. Consequently, comparing denied procedures to total procedures, as we do in Tables 2 and 3, involves comparing slightly different sets of figures. However, we received assurances from the CDS and the department that for this report this data provides a reasonably accurate comparison of the number and the types of procedures billed and paid or denied from 1981 to 1983.

TABLE 2

SUMMARY OF PROCEDURES PAID AND DENIED BY THE CDS 1981 THROUGH 1983

Billed Procedures	1981 Number of Procedures	1981 Percent of Total	1982 Number of Procedures	1982 Percent of Total	1983 Number of Procedures	1983 Percent of Total
Paid	9,599,748	96.2	8,729,640	92.7	6,679,481	91.7
Denied	378,147	3.8	691,000	7.3	606,568	8.3
Total Billed Procedures	9,977,895	100.0	9,420,640	100.0	7,286,049	100.0

Source: California Dental Service; we did not audit these figures.

The table shows a substantial increase in the number of procedures denied in 1983 compared to the number of procedures denied in 1981. The table also shows that while the number of procedures denied by the CDS between 1981 and 1983 increased, the total number of procedures billed by providers decreased by nearly 2.7 million in 1983.*

*Effective June 30, 1982, medically indigent adults were no longer eligible to receive benefits under the Denti-Cal program. The department's senior dental consultant stated that this program change contributed to the decrease in the total number of procedures billed by providers in 1982 and 1983.

To determine whether the rate at which certain procedures were denied increased faster for some procedures than for others, we obtained department data on specific procedures denied and total procedures billed for 1981 and 1983. In Table 3 on the next page, we summarize by type of procedure the number of procedures billed and denied.

TABLE 3

SUMMARY OF PROCEDURES BILLED AND DENIED BY THE CDS DURING 1981 AND 1983

Type of Procedure	1981 Billed Procedures	1981 Denied Procedures	1981 Percent of Billed Procedures Denied	1983 Billed Procedures	1983 Denied Procedures	1983 Percent of Billed Procedures Denied
Fillings	2,716,066	32,335	1.2	1,561,614	136,597	8.8
Examinations	713,345	87,043	12.2	599,771	108,137	18.0
X-rays	3,656,311	63,457	1.7	3,024,844	105,024	3.5
Root Canals	138,716	9,603	6.9	113,982	15,289	13.4
Office Visits	186,862	20,549	11.0	146,752	26,871	18.3
Cleaning and Fluoride Treatments	779,978	33,372	4.3	644,229	44,988	7.0
Extractions	788,956	15,438	2.0	523,903	42,170	8.0
Denture Work	403,308	33,495	8.3	284,267	36,675	12.9
Drugs and Anesthetics	108,043	9,312	8.6	61,981	11,041	17.8
Crowns	178,734	13,213	7.4	141,901	16,996	12.0
Periodontics	125,819	23,964	19.0	61,903	21,242	34.3
Miscellaneous	181,757	36,366	20.0	120,902	41,538	34.4
Total	9,977,895	378,147	3.8	7,286,049	606,568	8.3

Source: Department of Health Services; we did not audit these figures.

Table 3 shows that for all types of procedures, the percent of billed procedures for which payment was denied increased from 1981 to 1983. The procedure that experienced the most significant increase in billings denied, however, was fillings. Although the total number of fillings billed decreased by nearly 1.1 million in 1983, the number for which the CDS denied payment increased from 32,335 in 1981 to 136,597 in 1983, an increase of more than 300 percent.

To determine the reasons for which the CDS most often denied payment for services, we reviewed a sample of 198 processed claims that included 291 denied procedures. We selected our sample from claims processed by the CDS during 1983. For the purpose of this report, we grouped the reasons for denial of the procedures into two broad categories: procedures denied for reasons that relate to X-ray documentation, and procedures denied for other reasons. Table 4 on the next page summarizes the denied procedures by category of denial.

TABLE 4

DENIED PROCEDURES BY CATEGORY OF DENIAL (1983)

Type of Procedure	Category of Denial: X-ray-Related Denials	Category of Denial: Denied for Other Reasons	Total Denied
Fillings	82	16	98
Examinations	0	56	56
X-rays	30	23	53
Root Canals	2	18	20
Office Visits	0	19	19
Cleaning and Fluoride Treatments	0	17	17
Extractions	7	4	11
Denture Work	0	7	7
Drugs and Anesthetics	0	5	5
Miscellaneous	1	4	5
Total	122	169	291
Percent of Total Denied Procedures	41.9	58.1	100

As shown in Table 4, 41.9 percent (122) of the procedures were denied for reasons that relate to required X-ray documentation. The remaining 58.1 percent (169) of the procedures were denied for other reasons.

Almost half (47.9 percent) of those procedures denied for other reasons were denied because of specific limitations of the Denti-Cal program, that allow a procedure to be performed only once per beneficiary during a specific period. For example, teeth cleaning is allowed only once during a twelve-month period. If the procedure is performed more than once in twelve months, the CDS denies payment for the second procedure. Some procedures were denied because they were not covered under the program or because adequate documentation of emergency office visits or other office visits was not provided. Dental examinations were the types of procedures most often denied.

Nearly half (48.3 percent) of the procedures denied for reasons related to X-ray documentation were denied because the X-rays submitted by the provider did not show the need for the procedure performed. For example, an X-ray submitted to support the need for a filling must clearly show the existence of a cavity. If a cavity was not evident from the X-ray, the CDS denied payment for the procedure. Other reasons that procedures involving X-rays were denied include the following: (1) the X-ray submitted was nondiagnostic;* (2) X-rays required to document the

*An X-ray is considered nondiagnostic when the image is too light, there is inadequate contrast, the X-ray is blurred, information necessary to properly diagnose a patient's condition is missing from the film, or the X-ray does not depict the entire tooth.

procedure were not submitted; and (3) additional X-rays were required to support the procedure. Fillings were the procedure most often denied for X-ray-related reasons. As noted in Table 3, fillings was also the procedure that experienced the largest increase in the number of procedures denied between 1981 and 1983.

Without further analysis we cannot conclude that the increased rate of denials resulted solely from the department's standards regarding X-ray documentation. Based on our analysis of the reasons for which the CDS denied payment for procedures, however, it appears that the increase in the rate of denials occurred because of the department's and the CDS' stricter interpretation and compliance with all provisions of the criteria manual.

Some Providers Believe That Documentation Requirements of the Denti-Cal Program Are Excessive

Denti-Cal providers whom we interviewed contend that the quality and quantity of documentation that the department requires providers to submit with each claim is excessive. The department maintains that its requirements are appropriate. Since judgment on this matter requires professional expertise in dental science, we do not present an opinion on the conflict. We do, however, report the views of the providers, the department, and the CDS.

We met with five Northern California dental providers to discuss their concerns about the documentation requirements of the Denti-Cal program. The first concern the providers identified is that the CDS will not pay a claim unless the X-ray accompanying the claim fully and clearly depicts the entire tooth that is to be worked on and the area surrounding it. For example, according to the providers, if a provider identifies an abscessed tooth in an X-ray and extracts the tooth, the CDS denies payment for the extraction if the entire tooth is not visible on the X-ray even though the abscess is clearly shown.

Four of the providers we interviewed stated that an X-ray is of acceptable quality if it contains sufficient information for the provider to make a diagnosis and for the CDS to verify the provider's diagnosis. The fifth provider agreed that X-rays are acceptable if they enable the provider to make a diagnosis; this provider contended, however, that it is not the CDS' responsibility to verify diagnoses.

In response to the objections of providers, CDS officials told us that the CDS must deny payment for a procedure if the provider does not sufficiently document the need for the services. Sufficient documentation includes X-rays that meet the department's standards. The CDS must adhere to the requirements of the Denti-Cal program, as established and interpreted by the department.

There appears to be little agreement within the dental profession about what constitutes an acceptable X-ray. We found that

even dental schools do not agree on whether an X-ray must depict the entire tooth to be considered an acceptable X-ray. In March 1983, for example, the Sacramento District Dental Society, representing licensed dentists in five Northern California counties, asked administrators in California dental schools the following question: "Are radiographs [X-rays] that fail to depict the entire tooth, yet are clearly diagnostic for the procedure rendered, an acceptable standard of care?" Of the seven responses received, three respondents answered yes, two respondents said no, one respondent suggested that such an X-ray probably would constitute an acceptable standard of care, and the remaining respondent indicated that such an X-ray might not necessarily reflect an acceptable standard of care.

The second concern identified by the providers we interviewed is that the department's requirement for X-rays exceeds that which prudent practice would require. The providers explained that they use professional judgment in determining when to take X-rays; they asserted that the department should neither require X-rays primarily for the purpose of confirming the need for dental service nor deny claims because the provider did not submit X-rays that he or she considered unnecessary.

The criteria manual allows providers to submit narrative in lieu of X-rays in instances where the beneficiary refuses to permit X-rays or where the need for the service is observable and the provider does not wish to subject the beneficiary to unnecessary radiation. The providers told us, however, that the CDS will not accept these statements

in lieu of X-rays. Officials at the department and a CDS official confirmed this statement. According to these officials, the only exceptions to the policy requiring X-rays could apply to pregnant women, children, and beneficiaries who have received extensive radiation therapy. The CDS official added that the narrative may also be acceptable in emergency situations in which X-ray equipment is not available.

Because these exceptions do not appear in the criteria manual, we asked the department's senior dental consultant to comment on them. He stated that pregnant women, children, and beneficiaries who have received extensive radiation therapy constitute the groups of beneficiaries who would most frequently refuse to permit X-rays.

According to the providers we interviewed, X-rays that do not provide a clinical benefit to the beneficiary are unnecessary and may, in fact, expose the beneficiary to unnecessary radiation. In the opinion of these providers, the department's requirement for such X-rays conflicts with federal recommendations. The U.S. Department of Health and Human Services defines any X-ray requested independently of the patient's health care as an "administrative X-ray" and states that administrative X-rays are usually a source of unnecessary radiation exposure. The Department of Health and Human Services recommends that administrative X-rays should not be required solely to monitor insurance claims or detect fraud, or to satisfy a prerequisite for payment. The providers we interviewed believe that the department does require administrative

X-rays (X-rays that the provider would not routinely require for dental examinations). However, the department's senior dental consultant told us that the department does not require administrative X-rays; it requires providers to submit X-rays that providers should normally take for examinations and treatment.

The Department Has Changed Its X-ray Requirements for Extractions and Restorations

According to the department's senior dental consultant for the Medi-Cal program, the department's general policies for X-rays require full depiction of a tooth to ensure that the provider examined the entire tooth and provided the appropriate treatment to the tooth. He added that in order for the provider to receive payment for both the treatment and the X-ray, the provider must submit X-rays that meet the department's standards. However, according to the consultant, the department informally notified the CDS that X-rays for extractions and restorations no longer need to show the entire tooth in order for the provider to receive payment for those procedures. X-rays for extractions must depict the entire root structure of the tooth; X-rays for restorations must portray the entire crown of the tooth. However, although this change of policy means that the provider may receive payment for the extraction or restoration, the department still will not pay for the X-rays used to justify the work unless the X-rays meet the department's standards for diagnostic X-rays.

According to the CDS, however, the department orally changed its X-ray policy only for extractions. A dental consultant at the CDS told us that the department orally modified that policy late in 1983. The manager of the department's CDS contract monitoring unit confirmed the consultant's statement that the department orally changed its X-ray policy late in 1983. At that time, according to the consultant, the department agreed to pay for extractions as long as the X-ray justified the need for the extraction. According to the CDS dental consultant, the CDS immediately implemented the department's oral change in X-ray policy regarding extractions.

The department notified the CDS in writing of the change of X-ray policy for restorations on April 17, 1984, and of the change of policy for extractions on May 14, 1984. Because these changes of policy for X-rays are so recent, we were unable to determine the effect of the changes on the CDS' processing of claims that providers submit for payment.

CONCLUSION

Since 1982, when the Department of Health Services began to more vigorously oversee the operation of the Denti-Cal program, the percentage of billed dental procedures for which the California Dental Service denied payment has increased. Between 1982 and 1983, the rate at which the CDS erroneously paid for services declined considerably and the rate at which

the CDS denied payment increased. Some providers believe that the department and the CDS are too strict in interpreting and applying criteria for X-rays required to justify payment for dental services. The department, which recently modified its X-ray policies for extractions and restorations, maintains that it requires only X-rays that providers should normally take for examinations and treatment.

OTHER INFORMATION REQUESTED BY THE LEGISLATURE

In addition to providing information on the Department of Health Services' changes in its administration of the Denti-Cal program, we were asked to provide information in two other areas: whether the number of Denti-Cal providers has changed in recent years, and how many X-rays are necessary to justify payment for Denti-Cal procedures.

We were unable to determine the number of individual dentists enrolled in the Denti-Cal program because the CDS enrolls providers by billing offices rather than by individual dentists. We were, however, able to obtain information on the number of billing offices receiving payment from the Denti-Cal program. The number of Denti-Cal billing offices has remained relatively stable over the past three years. According to CDS records, the Denti-Cal program paid claims filed by 12,573 billing offices in 1981, 12,405 billing offices in 1982, and 12,076 billing offices in 1983. These figures demonstrate a slight decline in the number of billing offices between 1981 and 1983. We could not determine if this decline in the number of billing offices represents a decline in the actual number of dentists providing services to Medi-Cal beneficiaries.

We were also asked to determine the number of X-rays necessary to justify payment for Denti-Cal procedures. The department's senior dental consultant and the providers we interviewed told us that, ideally, no Denti-Cal procedure should require more than one X-ray to justify

payment. However, the providers told us that the circumstances in which X-rays are taken are not always ideal. For example, frequently children move when X-rays are being taken. If the provider can make a diagnosis from the X-ray, but the X-ray does not meet the department's standards, the provider can either retake the X-ray or submit the poorer quality X-ray to the CDS and risk having the CDS deny payment because of the quality of the X-ray.

The department obtained its specific standards for diagnostic X-rays from the California Dental Association handbook Quality Evaluation for Dental Care, which was first published in 1977. The handbook describes two categories of satisfactory X-rays (excellent and acceptable) and two categories of unacceptable X-rays (not acceptable but could be corrected and not acceptable and cannot be corrected without retaking). The X-ray standards adopted by the department match the California Dental Association's category for excellent X-rays. (See Appendix B for the California Dental Association's general guidelines for X-rays.) The department's dental consultant told us that the department requires the same quality of X-rays as dental schools, which, he said, emphasize excellence in X-ray skills for their dental students. However, the manager of the department's CDS contract monitoring unit told us that when the department conducts its monthly audits, it does not challenge the CDS' payment of X-rays if the department's auditors determine that the X-rays meet the California Dental Association's criteria for the "acceptable" category of X-rays. He added that this practice does not constitute a change of X-ray policy on the part of the department.

We conducted this review under the authority vested in the Auditor General by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

for THOMAS W. HAYES
Auditor General

Date: June 4, 1984

Staff: Robert E. Christophel, Audit Manager
Steven Hendrickson
Allison G. Sprader
Linda Foster
Francine Ho

GEORGE DEUKMEJIAN, *Governor*

STATE OF CALIFORNIA

HEALTH and WELFARE AGENCY

OFFICE OF THE SECRETARY
1600 NINTH STREET, ROOM 460
Sacramento, California 95814
(916) 445-6951

May 31, 1984

Mr. Thomas Hayes
Auditor General
Office of the Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

Thank you for the opportunity to review a draft copy of your report, "Review of the Department of Health Services' X-ray Requirements for the Denti-Cal Program". It accurately describes requirements of this element of the program.

The essence of your report appears to be that the Department of Health Services has improved management of its contract with California Dental Service to insure payments are made only for Denti-Cal covered benefits. This has resulted in a significant increase in claim denials.

Sincerely,

David B. Swoap
Secretary

APPENDIX A

EXCERPT ON GENERAL POLICIES FOR RADIOGRAPHS (X-RAYS) FROM THE CRITERIA FOR DENTAL SERVICES UNDER THE MEDI-CAL PROGRAM

Radiographs

X-rays--General Policies

1. Radiographs are covered when taken in compliance with state and federal regulations for radiation hygiene, and when they fully depict subject teeth and associated structures by standard illumination, and are appropriate to the symptoms and conditions of the patient.

2. X-rays will be requested from a provider when a claim is submitted listing procedures that must be verified by radiographic examination and no x-rays are attached, except when the dentist explains why the service was necessary and includes a statement why x-rays were not taken.

3. If x-rays are not submitted with the treatment form because the beneficiary (or parent) refused to have x-rays taken or because the need for the service is observable and the dentist does not wish to subject the beneficiary to unnecessary radiation, a statement to this effect must be included on the treatment form. Repeated restorative care without appropriate x-rays may lead to a prior authorization requirement.

4. Nondiagnostic x-rays are not payable.

   X-rays are considered diagnostic when:

   a. Standard illumination permits differentiation between the various structures of the tooth, the periodontal ligament spacings, the supporting bone, and normal anatomic landmarks.

   b. All crowns and roots, including apices are fully depicted together with interproximal alveolar crests, contact areas, and surrounding bone regions.

   c. Images of all teeth and other structures are shown in proper relative size and contour with minimal distortion and without overlapping images where anatomically possible.

EXCERPT FROM THE GENERAL GUIDELINES FOR RADIOGRAPHS IN THE CALIFORNIA DENTAL ASSOCIATION HANDBOOK QUALITY EVALUATION FOR DENTAL CARE

RADIOGRAPHS **RADIOGRAPHS**

Quality Evaluation Rating System			Quality Evaluation Criteria and Abbreviations		
	Rating	Operational Explanation	Code Film Contrast, Density, Sharpness, Identification	Code Film Coverage	Code Image Defects
SATISFACTORY	R Range of Excellence Romeo Code: R Call: Romeo	The radiograph (or series of radiographs) is of satisfactory quality and provides the necessary information for diagnostic purposes.	Standard illumination permits differentiation between the various structures of the teeth, the periodontal ligament spacings, the supporting bone and normal anatomic landmarks. (Refer to General Guidelines)	All crowns and roots, including apices are fully depicted together with interproximal alveolar crests, contact areas and surrounding bone regions. (Refer to General Guidelines.)	Images of all teeth and other structures are shown in proper relative size and contour with minimal distortion and without overlapping images where anatomically possible. (Refer to General Guidelines)
	S Range of Acceptability Sierra Code: S Call: Sierra	The radiograph (or series of radiographs) is of acceptable quality, but exhibits one or more features which deviate from the ideal.	Differentiation between the various structures of the teeth, the periodontal ligament spacings, the supporting bone and anatomic landmarks require special viewing illumination: SDY Film **density** is excessive or insufficient, or SCT Film **contrast** is excessive or insufficient, or SDT Image **details** are inadequate, or SCS Films exhibit **creases,** or ST Films exhibit minor **stains:** but other films in the series allow interpretation of the regions in question.	SCOV All crowns and roots, including apices, in general, are depicted together with interproximal alveolar crests and contact areas, but **coverage** of the surrounding bone regions does not extend sufficiently to rule out or fully diagnose partially shown or suspected pathologic changes without additional radiographs or further evaluation by referral.	SDTS Images of some teeth and other structures are **slightly distorted,** or Images of some teeth and other structures exhibit **slight** SOLS interproximal **overlapping,** but the series of films provides sufficient diagnostic information.
NOT ACCEPTABLE	T Not Acceptable but could be corrected Tango Code: T Call: Tango	The radiograph (or series of radiographs) is not of acceptable quality, but the deficiency could be corrected.	TMT Current films are not **mounted,** or TID Films are not correctly **identified.**	TFFQ **Full** radiographic **series** is taken more than once every three years without specific indications, or TBW **Bitewing** series is taken more than once in a 12-month period without specific indications TVER **Edentulous regions** not shown. TIM Film series is **incomplete.**	Not applicable.
	V Not Acceptable; cannot be corrected without retaking Victor Code: V Call: Victor	The radiograph (or series of radiographs) is not of acceptable quality. The radiograph (or series of radiographs) does not provide the necessary information for diagnostic purposes.	Interpretation of possible pathologic changes in the dentition and/or the surrounding bone is uncertain: VDY Film **density** is inadequate, or VCTR Film **contrast** is inadequate, or VDT Image **detail** is inadequate, or VCS Films are severly **creased,** or VST Films are severly **stained.**	VCOV Film **coverage** is insufficient to diagnose pathologic changes in the interproximal, infradental, periradicular, and/ or retromolar regions, or VCC Radiographs exhibit **cone cutting,** rendering films non-diagnostic.	Images of teeth and other VDTS structures are **distorted** to the extent that interpretation of normal structures vs pathological changes is not possible, or Images of teeth and other VOLS structures are **overlapping** to the extent that interpretation of *normal* structures vs. pathological changes is not possible.

NOTE: The California Dental Association handbook states that the above "quality-evaluation criteria should be considered merely as aids for the discrimination between the four ratings for each characteristic. The determination of the rating of any given dental service is dependent upon the sound judgment of the peer-review examiners."

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps